JBER REFRACTIVE SURGERY CENTER INFORMATIONAL SHEET

Last, First, MI, Suffix (Jr., III):_____ **Rank:** _____

SSN (FMP/xxx-xx-xxxx): _____ **Age/DOB (annotate both):**_____ **Sex: M F**

Service: USAF USA USN/USMC Status: Active duty Reserve Guard

Occupation/AFSC (annotate both): _____ **Flying Status: Yes/ No ASC:** _____

Date of Separation/Retirement: _____
A date is absolutely required. If Indef, please give anticipated separation or retirement date

Contact Info

Home address (city): _____ Unit: _____

Phone (H): _____ Base:_____

Phone (C):_____ Phone (W): _____

e-mail: _____ e-mail: _____
place star by preferred method of contact

Commander's email (for profile processing) _____

Medical Information: (please annotate completely. If nothing to annotate, please write "nothing")

Drug Allergies/Sensitivities: _____

Current Medications: _____

Medical History: _____

Surgical History: _____

Do you now or have you ever had any of the following eye conditions?

Corneal infection/scars	yes / no	Glaucoma	yes / no	Keratoconus	yes / no
Ocular Herpes infection	yes / no	Dry eyes	yes / no	Cataract	yes / no
Strabismus/lazy eye	yes / no	Eye surgery	yes / no	Eye injury	yes / no
Ocular allergies	yes / no	Retinal problems	yes / no	Ocular Rosacea	yes / no

Do you have any of these medical conditions?

Acne rosacea	yes / no	Pacemaker	yes / no	Psoriasis	yes / no
Diabetes	yes/no	Thyroid Disease	yes / no	Migraines	yes / no
Immunosuppression	yes / no	Tuberculosis or positive PPD		yes / no	

Do you have an autoimmune disease or have you been evaluated by a specialist for possible autoimmune disease (examples below)?
Rheumatoid arthritis, Lupus, Multiple Sclerosis, Sarcoid, Sjogren's, Irritable Bowel Disease, HLA B27, psoriasis, vitilligo

Have you ever taken the following? If yes, indicate LAST used:
Immitex (sumatriptan), Accutane (Isotretinoin), Cordarone (Amiodarone), Steroids, TB meds (INH), small pox vaccine

Have you ever worn contact lenses? Yes / No If yes, circle the type: Soft / Hard / Unsure
How many years? _____ How many hours per day? _____ What date did you last wear? _____

Females: Are you currently pregnant or planning to become pregnant in the next 6 months? Yes / No
Are you nursing or have you been nursing/pregnant in the last 6 months? Yes / No

List your hobbies or activities having special visual requirements (Ex: flying, swimming, golf, shooting, sewing)

Describe your expectations from refractive surgery: (Ex: to see the clock in the morning, while swimming)

****Soft contact lenses *must not be worn* 30 days prior to the preop exam or surgical date. Rigid Gas Permeable contacts *must not be worn* 90 days prior to the preop exam/surgical date. Initial here that you have read and understand this statement _____****